

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 1804 P. 3

PRINTED: 05/03/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 448491	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2017
NAME OF PROVIDER OR SUPPLIER MCKENDREE VILLAGE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37076		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253 SS-C	<p>483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide and maintain a clean, safe, comfortable and homelike environment in resident's rooms and resident's shared common areas for 2 of 3 units observed in the facility.</p> <p>The findings included:</p> <p>Observations of resident rooms during the environmental tour on 4/26/17 at 9:35AM with the Maintenance Director, revealed the following:</p> <ol style="list-style-type: none"> 1. Rooms 177 East (E), 260E, 267E and 282E, had over-the-bed tables with missing areas of veneer which allowed the sharp edges of the wood to be exposed. 2. Room 177E had several brown stains on the wall near the bed and bathroom. 3. The 2 East Lounge/TV area had a black over-stuffed recliner with several large areas on the arms of the chair with missing vinyl exposing the cloth material beneath. A brown recliner in this same area had two large holes in the vinyl on the right side of the chair exposing the material beneath and prevented the chairs from being sanitized after use. 4. Room 266E had a leaky bathroom faucet that continued to leak water even after both handles were turned to the off position. The Maintenance Director confirmed at this time that the faucet could not be shut off and should be replaced. 5. Rooms 267E and 280E had bathroom toilet 	F 253	<p>Allegation of Substantial Compliance</p> <p>McKendree Village (herein after referred to as "facility") has and continues to be in substantial compliance with 42 CFR Part 482.13, Requirements for Long Term Care Facilities. McKendree Village has or will have substantially corrected the alleged deficiencies and achieved substantial compliance by the date specified herein.</p> <p>This Plan of Correction constitutes McKendree Village's allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected by June 9, 2017.</p> <p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with 42 CFR Part 482.13, Requirements for Long Term Care Facilities, McKendree Village has taken or will take the actions set forth in this plan of correction.</p>	June 9, 2017	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	<p>Continued From page 1</p> <p>risers with areas where the paint had been chipped exposing the bare metal beneath, and prevented the resident's equipment from being sanitized effectively after use.</p> <p>6. Rooms 177E, 267E-Bed A, and 263E-Bed A, had drywall behind the head of the bed that was marred and gouged. In the residents' bathroom for rooms 266E and 268E, the drywall corner wall edges were gouged and had areas of missing cove base. The drywall below the air conditioner unit in room 266E was gouged and had an area that was missing drywall. Black marks were observed along the walls in room 268E-Bed A.</p> <p>7. Room 267E-Bed A, had a blue floor mat with a tear in the corner of the vinyl exposing the foam beneath, thus preventing the item from being sanitized after use.</p> <p>8. Room 268E and 267E, the closet doors were off the track and would not open. The Maintenance Director confirmed that the closet doors were off the track and was in need of repair.</p> <p>9. Room 167E-Bed A, the carpet had several areas that were stained and the cords/outlets for the cable protruded from the wall.</p> <p>10. Rooms 279E-Bed A, 266E-Bed A, and 263E-Bed A, had wheelchairs with vinyl-covered armrests that were cracked, exposing the material beneath. The Maintenance Director confirmed that the vinyl surfaces had sharp edges.</p> <p>11. Room 267E, had the heat/air conditioner unit rusted over on the exterior and interior of the unit, thus preventing the unit from being cleaned or sanitized.</p> <p>12. Room 267E-Bed B, the cubicle curtain had areas of brown stain.</p> <p>13. Room 263E, the drain was missing from the resident's bathroom faucet. The toilet paper bar was missing which prevented the roll of toilet</p>	F 253	<p>F 253 Housekeeping and Maintenance Services</p> <p>The facility has and will continue to provide housekeeping and maintenance services to maintain an orderly, sanitary, comfortable and homelike environment in accordance with Federal, State or local standards.</p> <p>On or before June 9, 2017 the Health Center Nursing staff, the Health Center Environmental Services staff and Health Center Maintenance staff will attend an inservice. Any staff member not in-serviced by this date will be removed from the schedule until the in-service has been completed. The in-service will be conducted by the Director of Nursing, Facilities Director or Designee and will include:</p> <ol style="list-style-type: none"> 1. Review of the regulation 2. Review of the statement of deficiency 3. Review of the plan of correction 4. Process for reporting and correcting broken or damaged equipment, furniture or fixtures <p>On or before June 9, 2017 the</p>	June 9, 2017	

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F 253	Continued From page 2 paper from being attached to the toilet roll holder. Interview with the Maintenance Director on 4/26/17 at 12:30 PM, indicated the maintenance staff viewed each resident's room once a month for maintenance repair issues. The Maintenance Director provided the surveyor with documents titled, "Department Monthly PM (preventative maintenance) Check List" dated January, February, March and April 2017. Review of the documentation in the presence of the Administrator and Maintenance Director revealed all of the documents indicated the items were "OK." The Maintenance Director confirmed the facility staff failed to identify maintenance and housekeeping issues.	F 253	<p>F 253 continued following will have occurred:</p> <ol style="list-style-type: none"> 1. Over bed tables in 177E, 260E and 282E replaced 2. Wall in 177E repaired and painted 3. Damaged recliners in the 2 East Lounge replaced 4. Leaking faucet in 266E repaired 5. Bathroom toilet risers in 267E and 260E repaired and repainted. 6. Walls in 177E, 267E-A, 263E-A, 266E, 269E repaired and painted 7. Fall mat in 267E replaced 8. Closet doors in 269E and 267E repaired. 9. Carpet in 167E cleaned and cords/outlets placed appropriately 10. Wheel chair arm rests in 279E-A, 266E-A and 263E-A replaced 11. Heating and air conditioning unit in 267E repaired or replaced 12. Cubicle curtains in 267E-B replaced 13. Bathroom faucet/sink and toilet paper holder in 263E repaired or replaced <p>On or before June 7, 2017, the Facilities Director or designee will</p>		

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F 253	Continued From page 2 paper from being attached to the toilet roll holder. Interview with the Maintenance Director on 4/26/17 at 12:30 PM, indicated the maintenance staff viewed each resident's room once a month for maintenance repair issues. The Maintenance Director provided the surveyor with documents titled, "Department Monthly PM (preventative maintenance) Check List" dated January, February, March and April 2017. Review of the documentation in the presence of the Administrator and Maintenance Director revealed all of the documents indicated the items were "OK." The Maintenance Director confirmed the facility staff failed to identify maintenance and housekeeping issues.	F 253	F 253 continued complete a review of 150 resident rooms and common areas to ensure continued compliance with F253. On or before June 7, 2017 the Administrator, Director of Maintenance or designee will monitor for continued compliance through Quality Improvement audits. (See Attachment A). Audits will be completed on 5 resident rooms per unit weekly for one month and monthly for one quarter, or until 95% compliance for two consecutive months is achieved. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring.		

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F 279 SS=D	<p>483.20(d); 483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the</p>	F 279	<p>F 279 Develop Comprehensive Care Plans</p> <p>The facility has and will maintain resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.</p> <p>On or before June 9, 2017 the Licensed Nurses and Social Workers will attend an in-service. Any staff member not in-serviced by this date will be removed from the schedule until the in-service has been completed. The in-service will be conducted by the Director of Nursing or Designee and will include:</p>	June 9, 2017	

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F 279	<p>Continued From page 3</p> <p>comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(5).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p>	F 279	<p>F 279 continued</p> <ol style="list-style-type: none"> 1. Review of the regulation 2. Review of the statement of deficiency 3. Review of the plan of correction 4. Review of individualized psychosocial care planning <p>Resident #209's care plan was updated on April 27, 2017 to include an individualized psychosocial care plan.</p> <p>On or before June 7, 2017, 100% of care plans of residents with an order for anxiolytics will be reviewed to ensure continued compliance with F279.</p> <p>On or before June 7, 2017 the Administrator or designee will monitor for continued compliance through Quality Improvement audits. (See Attachment B). Audits of at least 5 Care Plans will be completed weekly for one month and monthly for one quarter, or until 95% compliance is achieved for 2 consecutive months. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring.</p>		

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F 279	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and interview, the facility failed to ensure an individualized psychosocial care plan was developed for 1 resident (Resident #209) of 21 residents reviewed.</p> <p>The findings included:</p> <p>Review of Resident #209's "Social Services Admission Assessment," dated 7/11/16, indicated under the section titled, "Customary Routine/Preferences" the form contained several options to select from to document the resident's preferences for daily living. However, the review indicated the staff that completed the assessment did not select any of the options and instead entered a handwritten note over the top of the section that read, "Resident (is) total care."</p> <p>Review of Resident #209's quarterly Minimum Data Set (MDS-a comprehensive assessment completed by the facility staff that assists with care planning) dated 1/17/17, indicated the facility admitted the resident on 7/8/16 and re-admitted the resident from acute care on 1/4/17. The staff documented in the assessment the resident had severely impaired cognitive skills for daily decision-making. Under "Section I- Active Diagnoses" the assessment indicated the resident's "Psychiatric/Mood Disorder" diagnoses listed "Depression." Under "Section N- Medications, item N0410" the assessment indicated the resident received antidepressant medication on all 7 days of the assessment's 7-day evaluation period.</p> <p>Review of Resident #209's April 2017 "Physician's</p>	F 279			

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F 279	<p>Continued From page 5</p> <p>Orders" indicated the resident's diagnoses included, but were not limited to, Anxiety and Depression. The resident's ordered medications included:</p> <p>a. Citalopram (Celexa- an antidepressant medication) 40 milligrams (mg) daily (ordered 12/5/16); and</p> <p>b. Lorazepam (Ativan- and antianxiety medication) 0.5 mg 1/2 tablet (0.25 mg) every 4 hours as needed for anxiety (ordered 11/10/16).</p> <p>Review of the resident's "Daily Skilled Nurse's Notes" for the dates the resident received the as needed lorazepam indicated on 4/5/17 at 9:00 PM the nurse documented the resident had "trouble falling/staying asleep/sleeping too much" but failed to indicate which of the 3 sleep symptoms the resident exhibited. The nurse also documented the resident had a "poor appetite" and "trouble concentrating. Further review of the of the form (front and back) indicated the staff provided no additional information related to the resident's mood and/or behavioral symptoms or indicated what non-pharmacological interventions were implemented to help manage the resident's mood and/or behavioral symptoms prior to administering the lorazepam.</p> <p>Review of Resident #209's April 2017 "Medication Record" indicated the resident received citalopram 40 mg daily from 4/1/17 through 4/26/17 for the treatment of Depression. The resident also received 1 dose of 0.25 mg of lorazepam (ordered for Anxiety) on 4/5/17, 4/6/17, and 4/13/17. The reverse side of the form indicated the staff did not document the time of medication administration, the symptoms the</p>	F 279			

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F 279	<p>Continued From page 6</p> <p>resident exhibited that warranted the administration of lorazepam, or a follow up evaluation of the medication's effectiveness</p> <p>Review of Resident #209's active care plan indicated the resident had a "Problem/Need," dated 7/26/16, which read: "(The resident) is managed with Celexa for Depression." The "Goal and Target Date" read: "No change in mood will be observed thru (sic) the next 90 days." The "Approaches" listed included:</p> <ul style="list-style-type: none"> - "Visit PRN (as needed)." - "Resident is aphasic (cannot speak) with severely impaired cognitive abilities." - "Observe and meet needs." - "Observe (sic) for changes in mood." <p>Further review of the care plan indicated the resident had a "Problem/Need," dated 7/20/16, which read: "Potential for side effects from use of psychotropic medication." The "Goal and Target Date" read: "Will not have adverse side effects from psychotropic medication thru (sic) next 90 days." The "Approaches" listed included:</p> <ul style="list-style-type: none"> - "Document daily on psychoactive medication flow sheet." - "Continued evaluation by Psych services of effectiveness and benefits of medication. Notify physician of recommendations." - "Monitor q (every) shift for adverse effects/adverse reactions such as dizziness, weakness, drowsiness, slurred speech, 	F 279			

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F 279	<p>Continued From page 7</p> <p>confusion, urinary retention, or hypotension (low blood pressure)."</p> <p>"Administer medication as ordered."</p> <p>"Notify MD (Medical Doctor)/NP (Nurse Practitioner) of adverse reactions and changes in mental status."</p> <p>Continued review revealed the resident's care plan did not include information related to the resident's diagnosis of Anxiety or order for lorazepam, the resident's individualized target mood symptoms and/or behaviors which the staff were to monitor for or how often the monitoring should occur, or any person-centered, non-pharmacological interventions to try to help manage the resident's anxiousness or depressive symptoms prior to administering the resident's PRN lorazepam.</p> <p>During an interview on 4/26/17 at 8:40 AM, Certified Nursing Technician (CNT) #3 stated the resident required total assistance with all care needs due to her history of a stroke. The CNT stated the resident was "moody at times" but did not seem anxious or show any behaviors. CNT #3 stated when the resident becomes "moody" she tells the nurse and the nurse gives the resident medication if needed.</p> <p>During an interview on 4/26/17 at 12:25 PM, Registered Nurse (RN) #9 stated that Resident #209 will occasionally yell out during care.</p> <p>During an interview on 4/26/17 at 12:50 PM, MDS Coordinator #2 stated that Social Services is responsible for the behaviors and discharge planning sections of the residents' care plans.</p>	F 279			

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F 279	Continued From page 8	F 279			
F 280 SS=D	<p>During an interview on 4/26/17 at 1:00 PM, the Social Worker stated care plan conferences are completed every quarter with Resident #209's spouse at which time they discuss the resident's progress, any concerns, and any changes that have been made or need to be made to the resident's treatment plan. Any changes are then incorporated into the care plan.</p> <p>483.10(c)(2)(i-ii,iv,v)(3), 483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:</p> <p>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.</p> <p>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and</p>	F 280	<p>F 280 Right to Participate Planning Care-Revise CP</p> <p>The facility has and will continue to have accurate and individualized resident care plans.</p> <p>On or before June 9, 2017 the Health Center Licensed Nurses and CNTs will attend an in-service. Any staff member not in-serviced by this date will be removed from the schedule until the in-service has been completed. The in-service will be conducted by the Director of Nursing or Designee, and will include:</p> <ol style="list-style-type: none"> 1. Review of the regulation 2. Review of the statement of deficiency 3. Review of the plan of correction 4. Review of bleeding precautions for anticoagulants. 	June 9, 2017	

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PRINTED: 05/03/2017
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER MCKENDREE VILLAGE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37076		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 9 shall support the resident in this right. The planning process must—</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be—</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to—</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined</p>	F 280	<p>F 280 continued Resident #209's care plan was updated on April 27, 2017 to include bleeding precautions</p> <p>On or before June 7, 2017, 100% of care plans for other residents on anticoagulants will be reviewed to ensure compliance with F280.</p> <p>On or before June 7, 2017, the Administrator or designee will monitor for continued compliance through Quality Improvement audits. (See Attachment B). Audits of at least 5 Care Plans will be completed weekly for one month and monthly for one quarter, or until or until 95% compliance is achieved for 2 consecutive months. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring.</p>		

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F 280	<p>Continued From page 10</p> <p>not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of the manufacturer's package insert, medical record review, and interview, the facility failed to revise the care plan for the use of an anticoagulant (blood thinner) medication to communicate the risks of the medication, the signs and symptoms of complications to report to nursing, and the interventions to implement to minimize the risk of complications for 1 resident (#209) of 5 residents reviewed for medication administration of 21 residents reviewed.</p> <p>The findings included:</p> <p>Review of the drug manufacturer's package insert information for Coumadin (also known by the generic name of warfarin sodium) dated 2016, revealed the following information:</p> <p>"Coumadin is indicated for: Prophylaxis (prevention) and treatment of venous thrombosis (blood clot in a vein) and its extension, pulmonary embolism (PE) (a blood clot in the lungs)....</p> <p>Warnings and Precautions...Hemorrhage (uncontrolled bleeding) Coumadin can cause major or fatal bleeding...."</p>	F 280			

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F 280	<p>Continued From page 11</p> <p>Review of the drug manufacturer's package insert information for Levaquin (an antibiotic medication), revised 9/2008 revealed the following information:</p> <p>"Levaquin is a(n)...antibacterial indicated in adults...with infections caused by designated, susceptible bacteria ...Drug Interactions...Warfarin effect may be enhanced. Monitor prothrombin time, INR (lab tests), watch for bleeding..."</p> <p>Medical record review revealed Resident #209 was readmitted to the facility on 1/4/17 with diagnoses including Atrial Fibrillation (a heart rhythm disorder), Pulmonary Embolism (blood clot in the lung), Deep Vein Thrombosis (a blood clot usually in an extremity), and Hypertension</p> <p>Review of Resident #209's April 2017 "Physician's Orders" indicated the resident's prescribed medications included:</p> <p>a. Warfarin (an anticoagulant or blood thinner medication) 5 milligrams (mg) daily re-ordered on 3/30/17. A note on the medication order read, "High Risk."</p> <p>b. Levaquin (an antibiotic medication) 500 mg daily for 10 days (no order date entered on the handwritten entry).</p> <p>Review of the resident's April 2017 "Medication Record" dated 4/15/17, indicated the resident received warfarin 5 mg daily at 3:00 PM and began receiving Levaquin 500 mg daily on 4/15/17 for 10 days.</p> <p>Review of the resident's active care plan</p>	F 280			

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F 280	<p>Continued From page 12</p> <p>indicated the care plan did not include information related to the resident's use of warfarin, its "High Risk" classification as noted on the "Physician's Orders, its potential to cause uncontrolled bleeding (which was increased by the addition of Levaquin), the signs and symptoms of complications, or the interventions for the staff to implement to minimize the risk of uncontrolled bleeding.</p> <p>During an interview on 4/26/17 at 12:25 PM, Registered Nurse (RN) #9 stated the anticoagulant medication should be on the resident's care plan including symptoms to monitor while the resident was taking the medication.</p> <p>Interview on 4/26/17 at 12:50 PM, with MDS Coordinator #2 revealed Resident #209's care plan did not contain information related to warfarin use and added that it should be on the resident's care plan. MDS Coordinator #2 stated that the medication may have been added in between the resident's comprehensive MDS assessments and care plan updates.</p> <p>During an interview on 4/26/17 at 1:12 PM, the Director of Nursing confirmed the resident's use of the anti-coagulant medication should have been on the resident's care plan.</p>	F 280			
F 329 SS=D	<p>483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--</p>	F 329	<p>F 329 Drug Regimen is Free From Unnecessary Drugs</p> <p>The facility has and will continue to complete appropriate monitoring and documentation of resident behaviors.</p>	June 9, 2017	

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F 329	<p>Continued From page 13</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure 1 resident (#209) of 5 residents sampled for unnecessary medication use of 21 residents reviewed, had adequate indications for the use of</p>	F 329	<p>F 329 continued</p> <p>On or before June 9, 2017 the Health Center Licensed Nurses will attend an in-service. Any staff member not in-serviced by this date will be removed from the schedule until the in-service has been completed. The in-service will be conducted by the Director of Nursing or Designee, and will include:</p> <p>Review of the regulation Review of the statement of deficiency Review of the plan of correction Behavior monitoring of residents on anxiolytic medications Completion of the behavior documentation form</p> <p>The behavior monitoring sheet for resident #209 was updated May 1, 2017.</p> <p>On or before June 7, 2017, Care Team Managers will audit 100% Behavior Monitoring forms for all residents on anxiolytic medications to ensure continued compliance with F329.</p>		

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F 329	<p>Continued From page 14</p> <p>psychotropic medications evidenced by the staff's failure to document the resident's targeted mood and behavioral symptoms, failure to document the potential adverse effects of the resident's psychotropic medications, failure to attempt to implement non-pharmacological interventions prior to the administration of "as needed" psychotropic medication, and failure to evaluate the resident for the ongoing effectiveness and adverse effects of psychotropic medication use.</p> <p>The findings included:</p> <p>Medical record review of Resident #209's quarterly Minimum Data Set (MDS), a comprehensive assessment completed by the facility staff that assists with care planning, dated 1/17/17, indicated the facility re-admitted the resident from acute care on 1/4/17. The staff documented in the assessment that the resident had severely impaired cognitive skills for daily decision-making, had not had an acute change in mental status, but exhibited symptoms of delirium as evidenced by "continuous inattention" and an "altered level of consciousness." Under "Section D- Mood, item D0600: Total Severity Score" the staff documented a "00," which indicated the resident exhibited no symptoms of Depression during the 14-day assessment period. Under "Section E- Behavior" (Items E0100 through E1100 of the assessment) indicated the resident exhibited no symptoms of psychosis or behaviors toward self or others, and did not reject care or exhibit wandering during the 7-day assessment period for this section. Under "Section I- Active Diagnoses" the assessment indicated the resident's "Psychiatric/Mood Disorder" diagnoses listed only "Depression." Under "Section N- Medications, item N0410" the assessment</p>	F 329	<p>F 329 continued</p> <p>On or before June 7, 2017, the Administrator or designee will monitor for continued compliance through Quality Improvement audits. (See Attachment B). Audits of 10 Behavior Monitoring forms of residents on anxiolytics will be conducted weekly for one month and monthly for one quarter, or until or until 95% compliance is achieved for 2 consecutive months. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring.</p>		

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F 329	<p>Continued From page 15</p> <p>indicated the resident received antidepressant medication on all 7 days of the assessment's 7-day evaluation period.</p> <p>Review of Resident #209's April 2017 "Physician's Orders" indicated the resident's diagnoses included, but were not limited to, Anxiety and Depression. The resident's ordered medications included:</p> <p>a. Citalopram (Celexa- an antidepressant medication) 40 milligrams (mg) daily (ordered 12/5/16); and</p> <p>b. Lorazepam (Ativan- and antianxiety medication) 0.5 mg 1/2 tablet (0.25 mg) every 4 hours as needed for anxiety (ordered 11/10/16).</p> <p>Review of Resident #209's active care plan indicated the resident had a "Problem/Need," dated 7/26/16, which read: "(The resident) is managed with Celexa for Depression." The "Goal and Target Date" read: "No change in mood will be observed thru (sic) the next 90 days." The "Approaches" listed included:</p> <p>- "Visit PRN (as needed)."</p> <p>- "Resident is aphasic (cannot speak) with severely impaired cognitive abilities."</p> <p>- "Observe and meet needs."</p> <p>- "Oserve (sic) for changes in mood."</p> <p>Further review of the care plan indicated the resident had a "Problem/Need," dated 7/20/16 ... "Potential for side effects from use of psychotropic medication." The "Goal and Target</p>	F 329			

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F 329	<p>Continued From page 16</p> <p>Date read: "Will not have adverse side effects from psychotropic medication thru (sic) next 90 days." The "Approaches" listed included:</p> <ul style="list-style-type: none"> - "Document daily on psychoactive medication flow sheet." - "Continued evaluation by Psych services of effectiveness and benefits of medication. Notify physician of recommendations." - "Monitor q [every] shift for adverse effects/adverse reactions such as dizziness, weakness, drowsiness, slurred speech, confusion, urinary retention, or hypotension [low blood pressure]." - "Administer medication as ordered." - "Notify MD (Medical Doctor)/NP (Nurse Practitioner) of adverse reactions and changes in mental status." <p>Continued review revealed the resident's care plan did not include information related to the resident's diagnosis of Anxiety or order for lorazepam; the resident's individualized target mood symptoms and/or behaviors which the staff were to monitor for or how often the monitoring should occur, or any person-centered, non-pharmacological interventions to try prior to administering the resident's PRN lorazepam; or to help manage the resident's anxiousness or depressive symptoms.</p> <p>Review of the resident's "Daily Skilled Nurse's Notes" for April 2017 (from 4/1/17 through 4/25/17) indicated on "Side One" of the notes, the staff documented the resident exhibited mood</p>	F 329			

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F 329	<p>Continued From page 17</p> <p>and/or behavioral symptoms on 9 occasions between 4/1/17 and 4/25/17 as follows:</p> <p>-On 4/1/17 at 9:00 PM the nurse documented the resident had "trouble concentrating" and was "fidgety."</p> <p>-On 4/5/17 at 9:00 PM the nurse documented the resident had "trouble falling/staying asleep/sleeping too much" but failed to indicate which of the 3 sleep symptoms the resident exhibited. The nurse also documented the resident had a "poor appetite" and "trouble concentrating."</p> <p>-On 4/11/17 at 9:00 PM and again on 4/12/17 at 11:30 PM the nurses documented the resident exhibited "verbal behaviors" but no mood symptoms.</p> <p>-On 4/15/17 at 2:30 AM the nurse documented the resident exhibited "verbal behaviors" but no mood symptoms. At 11:00 PM the nurse documented the resident was "fidgety."</p> <p>-On 4/16/17 at 10:00 PM, 4/18/17 at 11:00 PM, and on 4/19/17 at 8:30 PM the nurses documented the resident had "trouble concentrating."</p> <p>Review of "Side Two" of the "Daily Skilled Nurse's Notes" for April 2017 (from 4/1/17 through 4/25/17) indicated the staff provided no additional information related to the resident's mood and/or behavioral symptoms or indicated what actions/interventions were implemented to help manage the resident's mood and/or behavioral symptoms when they occurred.</p>	F 329			

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F 329	<p>Continued From page 18</p> <p>Review of the facility's "Psychoactive Medication Monthly Flow Record," (a form used by the staff to document behavioral symptoms and medication side effects) indicated the form included a section titled, "Section I: Target Behavioral Symptoms" for the staff to describe the resident's target behaviors. A second section on the form titled, "Section II: Side Effects" listed multiple potential medication side effects the staff could select depending on the medication ordered. To the right of both sections, the form included boxes for each day of the month by shift for the staff to document whether or not a resident displayed behaviors and/or medication-related side effects.</p> <p>Medical record review of a copy of Resident #209's April 2017 "Psychoactive Medication Monthly Flow Record," provided by the facility on 4/26/17, indicated under "Section I: Target Behavioral Symptom" the copy included the word "yelling" as the resident's target behavioral symptom. In addition, on the copy, the documentation boxes under "Section I" included the following documentation:</p> <p>-On 4/1/17, 4/2/17, 4/4/17, 4/7/17, 4/12/17, 4/15/17, and 4/23/17: Each shift (day, evening, and night) had an entry of "0";</p> <p>-On 4/3/17, 4/14/17, 4/16/17, 4/18/17, and 4/22/17: All shifts were blank;</p> <p>-On 4/5/17 and 4/6/17: The day shift had an entry of "1." The evening and night shift boxes had entries of "0";</p> <p>-On 4/13/17: The day shift had an entry of "1." The evening and night shift boxes were blank;</p>	F 329			

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F 329	<p>Continued From page 19</p> <p>-On 4/8/17, 4/20/17, 4/25/17, and 4/26/17: The day shift had an entry of "0." The evening and night shift boxes were blank;</p> <p>-On 4/9/17: The day shift box was blank and the evening and night shift boxes had entries of "0";</p> <p>-On 4/10/17, 4/21/17, and 4/24/17: The evening shift had entries on "0" and the day and night shift boxes were blank;</p> <p>-On 4/11/17 and 4/17/17: The day and evening shift had entries of "0" and the night shift box was blank;</p> <p>-On 4/19/17: The night shift box had an entry of "0" and the day and evening shift boxes were blank.</p> <p>Further review of the copied form indicated "Section II: Side Effects" remained blank.</p> <p>Review of Resident #208's April 2017 "Medication Record" indicated the resident received citalopram 40 mg daily from 4/1/17 through 4/26/17. The resident also received 1 dose of 0.25 mg of lorazepam on 4/5/17, 4/8/17, and 4/13/17. The reverse side of the form indicated the staff did not provide a time of administration of the as needed lorazepam, what symptoms the resident exhibited that warranted the administration of lorazepam, or a follow up evaluation of the medication's effectiveness.</p> <p>Review of a physician's "Progress Note," dated 4/18/17, indicated the physician documented the resident was evaluated for a follow up due to a recent diagnosis of Pneumonia. The physician</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER MCKENDREE VILLAGE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37078		
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F 329	<p>Continued From page 20</p> <p>documented, "...doing better with antibiotic. No other abnormalities (sic). No acute distress. Affect is appropriate." The physician's "Plan" made no mention related to the intended management of the resident's mood and/or behavior, or psychotropic medication use.</p> <p>Observation on 4/24/17 at 10:30 AM during an interview with Resident #209's spouse and responsible party revealed the resident sat in a geri-chair in her room, slightly reclined with her eyes closed. The resident remained asleep and exhibited no symptoms of distress throughout the family interview.</p> <p>Observation on 4/24/17 from 12:15 PM to 12:30 PM in the dining room on the nursing unit revealed the resident sat in a geri-chair at a dining room table with her spouse beside her. The resident was alert, made attempts to feed herself, and received assistance with intake from her spouse. The resident remained calm and exhibited no symptoms of distress throughout the observation.</p> <p>During an interview on 4/26/17 at 8:40 AM, Certified Nursing Technician (CNT) #3 stated the resident required total assistance with all care needs due to her history of a stroke. The CNT stated the resident was "moody at times" but did not seem anxious or show any behaviors. CNT #3 stated when the resident becomes "moody" she tells the nurse and the nurse gives the resident medication if needed.</p> <p>During an interview on 4/26/17 at 12:25 PM, Registered Nurse (RN) #9 stated if a resident receives a psychotropic medication for behavioral symptoms, the nurses must complete a "behavior</p>	F 329			

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F 329	<p>Continued From page 21</p> <p>flow sheet" on that resident. RN #9 stated that residents who receive antidepressant medication do not require a behavior flow sheet, only those who receive antianxiety or antipsychotic medications. The RN stated the nurses are required to perform a daily assessment of residents who take antipsychotic or antianxiety medications for any behavior symptoms and for any adverse reactions to the medications taken. The RN stated the nurses then complete the behavior flow sheets daily with their assessment information. RN #9 stated the "Skilled Nursing Notes" also have sections to fill out if a resident shows any mood or behavioral symptoms. RN #9 stated whenever the nurses administer a PRN psychotropic medication, they are required to document on the resident's "Medication Record" the date and time they administered the medication, the name and dose of the medication administered, and the reason the medication was administered. The nurses should then go back and document whether or not the medication was effective. RN #9 stated that Resident #209 will occasionally yell out during care, especially if she does not know the staff that is providing the care, and added, "But she doesn't do that with staff that she knows and trusts."</p> <p>During an interview on 4/26/17 at 1:12 PM, the Director of Nurses (DON) stated that she expected the nurses to complete a "Psychoactive Medication Monthly Flow Record" on any resident that receives a psychotropic medication, including antidepressants. The DON stated the form should list the resident's target behaviors and any potential medication side effects, and added that the nurses should assess the resident and document on the form every shift. The DON stated she was unaware that Resident #209's</p>	F 329			

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F 329	Continued From page 22	F 329			
F 332 SS=D	<p>"Psychoactive Medication Monthly Flow Record" for April was still blank and stated, "They (the nurses) should be documenting that information."</p> <p>483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>(f) Medication Errors. The facility must ensure that its-</p> <p>(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview the facility failed to administer an ophthalmic medication correctly for 1 resident (#204) and failed administer insulin timely for 1 resident (#34) resulting in a medication error rate of greater than 5% of 31 opportunities for medication administration observed.</p> <p>The findings included:</p> <p>Review of the facility's policy titled, "five rights of Medication Administration" dated 5/15 indicated, "...5. The RIGHT time, a. Before administering the medication, check to see when the last time the resident was medicated, if the time frequency is not within the time frame prescribed you MUST call the physician. B. Medications can be given 1 hour prior to the scheduled time up to one after the schedule time."</p> <p>Observations during the medication pass on 4/26/17 at 8:00 AM, revealed Licensed Practical Nurse (LPN) #12 attempted to instill 1 drop of the Artificial Tears ophthalmic medication (eye drops</p>	F 332	<p>F 332 Free of Medication Error Rates of 5% or more</p> <p>The facility has and will continue to ensure that its medication error rates are not 5% or greater.</p> <p>On or before June 9, 2017 the Licensed Nurses will attend an in-service. Any staff member not in-serviced by this date will be removed from the schedule until the in-service has been completed. The in-service will be conducted by the Director of Nursing or Designee and will include:</p> <ol style="list-style-type: none"> 1. Review of the regulation 2. Review of the statement of deficiency 3. Review of the plan of correction 4. Review of technique for eye drop administration. 5. Review of technique for insulin administration. <p>Nurse #1 was in-serviced regarding appropriate technique when performing eye drops administration on May 2, 2017.</p>	June 9, 2017	

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F 332	<p>Continued From page 23</p> <p>for the treatment of dry eyes) into Resident #204's eyes. LPN #12 lowered Resident #204's right lower eye lid and dispensed one drop of Artificial Tears medication. The drop landed on the skin below Resident #204's lower eye lid. Continued observation revealed resident #204 used his hands to push the eye drop into his right eye. Continued observation revealed LPN #12 asked Resident #204 whether the eye drop went into the right eye. Resident #204 stated that he was able to push the eye drop into his eye. Continued observation revealed LPN #12 proceeded to instill a drop of Artificial Tears medication into Resident #204's left eye. LPN #12 did not attempt to lower Resident #204's upper or lower eye lids. Continued observation revealed LPN #12 lowered the Artificial Tears medication bottle to within one-half inch of Resident #204's left eye and dispensed a drop of the Artificial Tears medication. Continued observation revealed the drop landed on the skin of Resident #204's upper left eye lid. Resident #204 took his fingers and moved his left upper eye lid and stated the eye drop went into his left eye.</p> <p>Medical record review of Resident #204's "Physician Orders" dated 4/6/17 confirmed, "Artifi (Artificial) Tears Sol (Solution) 2 drops in both eyes three time daily as needed for Tears Again."</p> <p>Interview on 4/26/17 at 8:10 AM, with LPN #12 confirmed Resident #204 will not allow you to touch his upper or lower eye lids. The surveyor requested LPN #12 to identify where it was documented that Resident #204 had requested nursing staff not to touch his upper or lower eye lids when instilling eye drops. Continued interview with LPN #12 confirmed it was not documented</p>			F 332	<p>F 332 continued</p> <p>Nurse #2 was in-serviced regarding appropriate technique when performing insulin administration on May 2, 2017.</p> <p>On or before June 7, 2017, Care Team Managers will observe medication pass for 100% of residents receiving eye drops or insulin to ensure continued compliance with F332.</p> <p>On or before June 7, 2017, the Director of Nursing or designee will monitor for continued compliance through Quality Improvement audits. (See Attachment C). The facility will complete 5 medications audits weekly for one month and monthly for one quarter, or until 100% compliance is achieved for 2 consecutive months.</p>		

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F 332	<p>Continued From page 24</p> <p>anywhere. LPN #12 stated he knew this information from taking care of Resident #204. Continued interview confirmed LPN #12 had administered only one drop into each of the resident's eyes and not two as indicated on the Physician's Order.</p> <p>Interview on 4/26/17 at 9:30 AM, with the Director of Nursing (DON) confirmed if Resident #204 expressed his preference that the nurses do not touch his eye lids when administering eye drops, the information should have been documented on the Medication Administration Record (MAR.) The DON indicated her expectation was that the nurse should have lowered the resident's right and left lower eye lids with a gloved finger and instilled the correct number of drops into the lower lid. The DON confirmed on 4/26/17 at 4:00 PM, there was no documentation Resident #204 had requested nursing staff not to touch his eye lids when administering eye drops.</p> <p>Observation during the medication pass on 4/26/17 at 11:15 AM revealed LPN #16 drew up 5 units of Lantus insulin (Medication to manage blood sugar level) in a syringe. LPN #16 stated to the surveyor that Resident #34's insulin was scheduled for 9:00 AM; however, the LPN was not able to administer the medication until now. LPN #16 entered Resident #34's room, and the resident requested that the insulin injection be administered in the upper left arm.</p> <p>Medical record review of Resident #34's "Face Sheet" indicated the diagnosis of Type 2 Diabetes Mellitus without complications.</p> <p>Review of Resident #34's "MAR (medication administration record)" dated April 2017 revealed</p>	F 332			

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F 332	Continued From page 25 a Physician's Order for, "Lantus 6 units subcutaneously twice daily." The time on Resident #34's MAR indicated 9am and 5pm. Interview on 4/26/17 at 11:30 AM, with the DON indicated the nurses have one hour before and one hour after the scheduled time of the medication to administer the medication. The DON stated Resident #34's Lantus insulin injection should have been administered no later than 10:00 AM. The DON confirmed the nurse should have notified the physician regarding Resident #34 Lantus insulin scheduled for 9:00 AM, not been administered within the prescribed time frame.	F 332			
F 371 SS=F	483.60(f)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371	F 371 Food Procure, Store/Prepare/Serve-Sanitary The facility has and will continue to ensure that food is procured from sources approved or considered satisfactory by Federal, State or local authorities and that food is stored, prepared, distributed and served under sanitary conditions. On or before June 9, 2017, Health Center Dietary staff will attend an in- service. Any staff member not in- served by this date will be removed from the schedule until the in-service has been completed. The in-service will be conducted by the Executive Chef or designee and will include:		June 9, 2017

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F 371	<p>Continued From page 26</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of the U.S. Public Health Service, Food and Drug Administration "Food Code", observation, and interview the facility failed to store canned goods and frozen foods in a sanitary manner, hold and serve cooked foods at acceptable temperatures, maintain kitchen sanitation, and ensure the functional order of food production equipment in accordance with professional standards for food service safety. This deficient practice had the potential to affect 128 residents who received food by mouth of 132 residents reviewed.</p> <p>The findings included:</p> <p>A review of the "Food Code" U.S. Public Health Service, Food and Drug Administration, U.S. Department of Health and Human Services, 2013, Annex 5, "Conducting Risk-based Inspections," provided the following information:</p> <p>"Basic operational and sanitation programs must be in place to:</p> <ul style="list-style-type: none"> -Protect products from contamination by biological, chemical, and physical food safety hazards -Control bacterial growth that can result from temperature abuse during storage -Maintain equipment, especially equipment used to maintain product temperatures." 	F 371	<p>F 371 continued</p> <ol style="list-style-type: none"> 1. Review of the regulation 2. Review of the statement of deficiency 3. Review of the plan of correction 4. Procedure for proper food preparation, storage and sanitation. <p>On or before June 9, 2017 the following will have occurred:</p> <ol style="list-style-type: none"> 1. Toasting machine cleaned 2. Warming oven cleaned 3. Humidified warming oven cleaned and metal exhaust fan cover cleaned 4. Floor of grill area cleaned 5. Wheeled cart cleaned 6. Reach-in double door refrigerator repaired to maintain proper temperature 7. Canned goods inspected. Damaged cans removed 8. Double door warming oven cleaned and insulation repaired 9. Warming oven near walk-in refrigerator cleaned 10. Portable carts cleaned 11. Food items in walk-in refrigerator covered 12. Steam well of 5 well steam table replaced 		

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F 371	<p>Continued From page 27</p> <p>Further review of the "Food Code," indicated the information under "Section §3-501.16, Time/Temperature Control for Safety Food, Hot and Cold Holding," provided the following information:</p> <p>"(A) Except during preparation, cooking, or cooling, or when time is used as the public health control... time/temperature control for safety food shall be maintained:</p> <p>(1) At 57 (degrees) Celsius (135 (degrees) F) or above...; or (2) At 5 (degrees) C (41 (degrees) F) or less."</p> <p>1. Observations of the kitchen on 4/24/17 beginning at 8:32 AM revealed the following:</p> <p>a. 8:48 AM: Observation of the sliced bread toasting machine revealed dried and clumped bread crumbs covered the ledge under the toasting section of the unit near the two control knobs. Both control knobs exhibited brown dried stains on their dial surfaces.</p> <p>b. 8:52 AM: Observation of two large warming ovens across from the meat slicer revealed both ovens were on and held baked sweet potatoes. Observation of the left warming oven revealed the interior floor of the oven had large area of black burnt-on overspill. Observation of the right warming oven revealed the middle rack had dried food debris on the metal rungs of the rack. During an interview at this same time, the Executive Chef stated the staff last cleaned the ovens on the previous Thursday.</p> <p>c. 8:57 AM: Observation of the humidified</p>	F 371	<p>F 371 continued</p> <p>On or before June 7, 2017, Executive Chef or designee will inspect other equipment and surfaces to ensure continued compliance with F329.</p> <p>On or before June 7, 2017, the Administrator or designee will monitor for continued compliance through Quality Improvement audits. (See Attachment D). The facility will complete audits weekly for one month and twice per month for one quarter, or until or until 95% compliance is achieved for 2 consecutive months. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring.</p>		

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F 371	<p>Continued From page 28</p> <p>warming oven revealed the interior surface of the oven door had dried spaghetti particles stuck to the surface. The bottom of the oven had dried food debris present near the right hinge of the door. During an interview at this same time, the Executive Chef stated the kitchen staff are to clean the warming ovens daily. The Executive Chef stated they served spaghetti for the dinner meal the night before (4/24/17) and the staff should have cleaned the warming oven after that meal. Further observation of the exterior of the oven revealed the metal exhaust fan cover had a large amount of lint covering all spines of the cover. The exhaust fan and cover were facing the food preparation area.</p> <p>d. 9:00 AM: Observation of the floor in the grill area revealed scattered areas of food debris covered the floor in front of and behind the grill. The floor surface also had a sticky quality to it. During an interview at this same time, the Executive Chef stated the staff sweep and mop the kitchen floor daily and a power wash is performed monthly.</p> <p>e. 9:02 AM: Observation of a wheeled cart in the food preparation area revealed the cart held 2 boxes of fresh broccoli on the top shelf of the cart. The surface of the top shelf had dried red food debris present on one corner.</p> <p>f. 9:05 AM: Observation of a reach-in double-door refrigerator in the food preparation area revealed the refrigerator contained a tray with multiple covered bowls of fresh cantaloupe and other fruits. Observation of the thermometer inside right side of the refrigerator revealed the thermometer registered 44 degrees Fahrenheit (F). The Food Services General Manager removed the trays of</p>	F 371					

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F 371	<p>Continued From page 29</p> <p>fresh fruit and instructed the Executive Chef to discard the bowls of fruit.</p> <p>g. 9:10 AM: Observation of the metal storage racks holding canned food goods revealed 1 large can of tomatoes with a 1-inch dent on the bottom seam of the can. Continued observation revealed a 106-ounce can of peaches had a 2-inch horizontal crease in the middle of the can underneath the label, and a 48-ounce can of grape juice had a 1-inch dent on the bottom seam of the can. During an interview at this same time, the Executive Chef stated the canned foods on the storage racks were intended for food production. The Executive Chef stated the dietary staff inspect the canned goods upon delivery and placement on the racks and added that the staff should have placed the dented cans on the rack for returns and not on the production racks.</p> <p>h. 9:18 AM: Observation of a double-door warming oven revealed the right interior door had a strip of black insulation approximately 10 inches in length across the top of the door. Approximately 6 inches of the insulation had separated from the door and hung downward inside the oven. Dried food debris littered the bottom interior surfaces of both sides of the oven.</p> <p>i. 9:20 AM: Observation of a warming oven near the walk-in refrigerator revealed the bottom interior of the oven had scattered dried food debris covering the bottom of the oven.</p> <p>j. 9:22 AM: Observation of the walk-in refrigerator revealed a portable cart that held boxed food goods had dried red food debris on one corner of the top shelf of the cart. During an interview at this same time, the Executive Chef stated he</p>	F 371			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445491		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2017	
NAME OF PROVIDER OR SUPPLIER MCKENDREE VILLAGE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37076			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 371	<p>Continued From page 30</p> <p>expected the staff to clean the carts daily and as needed.</p> <p>k. 9:28 AM: Observation of the walk-in freezer revealed a tray of bowls that contained frozen green pureed food. The plastic wrap covering the bowls had been pulled back and exposed 2 rows of bowls to the air. During an interview at this same time, the Executive Chef stated the tray of bowls should be fully covered with plastic wrap. The Food Service General Manager removed the tray from the rack for disposal.</p> <p>2. Observations on 4/25/17 beginning at 12:17 PM of the tray line preparation process for the lunch meal revealed the following:</p> <p>Food Service Supervisor (FSS) #4 brought a digital thermometer with a metal probe over to the 5-well steam table. FSS #4 stated the digital thermometer had been calibrated earlier that morning (4/25/17).</p> <p>Continued observation revealed 1 dietary staff member worked the steam table and placed hot foods on the plates in the tray line. Starting on the right of the steam table, FSS #4 proceeded to check the temperatures of the foods in each of the pans that sat in wells #1 through #5 (right to left). At approximately 12:28 PM, FSS #4 tested a pan of lima beans in the rear section of well #4 and obtained a temperature reading of 109 degrees F. FSS #4 stirred the lima beans, re-tested the temperature, and obtained the same reading of 109 degrees F. FSS#4 then removed the pan of lima beans from the well and handed the pan to the Executive Chef who left the tray line area with the pan. At 12:30 PM, FSS #4 tested a pan of pasta noodles in front section of</p>	F 371					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 31 well #4 and obtained a temperature reading of 130 degrees F. FSS #4 stirred the pasta noodles, re-tested the temperature, and obtained the same reading of 130 degrees F. FSS #4 removed the pan of pasta noodles from the well and handed the pan to the Executive Chef who left the tray line area with the pan. At this same time, FSS #4 stated, "The well (on the steam table) is not working. It was working when we started "serve-out" at 11:30 AM." At 12:33 PM, as FSS #4 tested the food in well #5, the Executive Chef and a dietary staff member returned to the steam table with the pans of lima beans and pasta noodles. FSS #4 tested the temperatures of the lima beans and the pasta noodles, both of which registered 142 degrees F. FSS #4 then removed some of the water from well #4 and added fresh hot water to the well. The serve-out process then continued to plate foods for the final trays in the last transport cart. Tray line serve-out ended at approximately 12:40 PM.	F 371			